US House of Representatives
Committee on Veterans' Affairs
Subcommittee on Health

Testimony of Dennis P. Culhane, Ph.D. and Stephen Metraux, MA, University of Pennsylvania
June 20, 2001

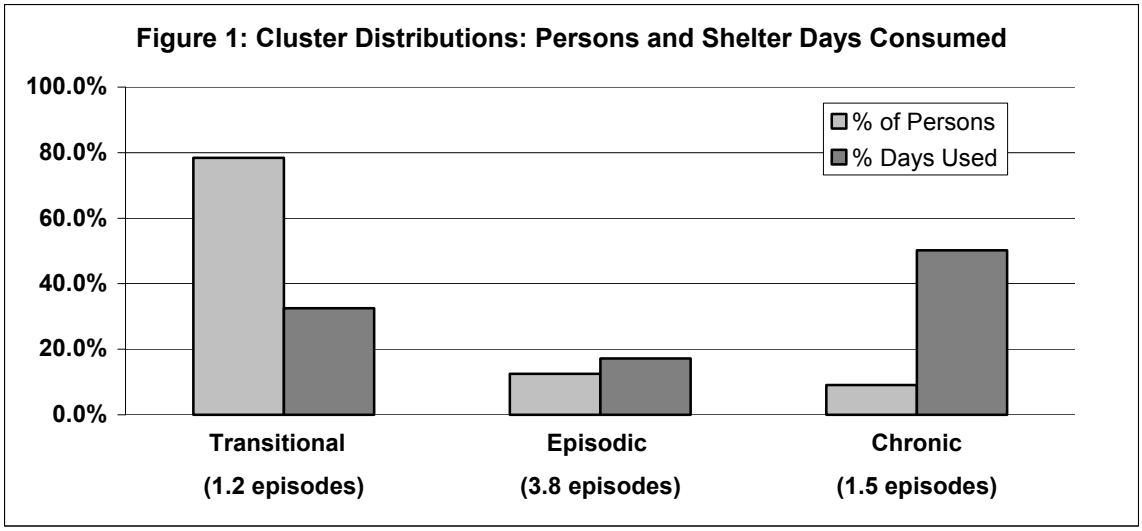
Chairman Smith and members of the committee, thank you for this opportunity to speak before you today.

Our recent research at the University of Pennsylvania has examined the dynamics of homelessness and the use of public shelters, and medical and psychiatric services in two large US cities, Philadelphia and New York. These two cities are relatively unique in the United States in that they each have over ten years of data, making it possible for us to analyze the trends and patterns in the use of these service systems over time. Today, we would like to summarize some findings from recent studies that we and our colleagues have completed and that are pertinent to homeless veterans and their use of services.

Veterans have been found primarily among the single adult homeless population – those persons experiencing homelessness while unaccompanied by family members. In 1997-98, of the 34,000 persons who responded to inquiries on veteran status in these two cities, 13% indicated that they were veterans. This percentage is higher when one looks at only the male shelter users, where the proportion is 16%.

Homeless single adults tend to be more visible than homeless families. They are therefore more consistent with the public's perception of the problem, even though homeless individuals represent only 40% of the homeless in these two cities. Among these persons, only a relatively small minority experience extended periods of homelessness. Among this minority, however, many have compelling health and social needs. It is in targeting the veterans in this minority that the VA can make the most efficient use of its homeless services and the greatest contribution towards ending homelessness.

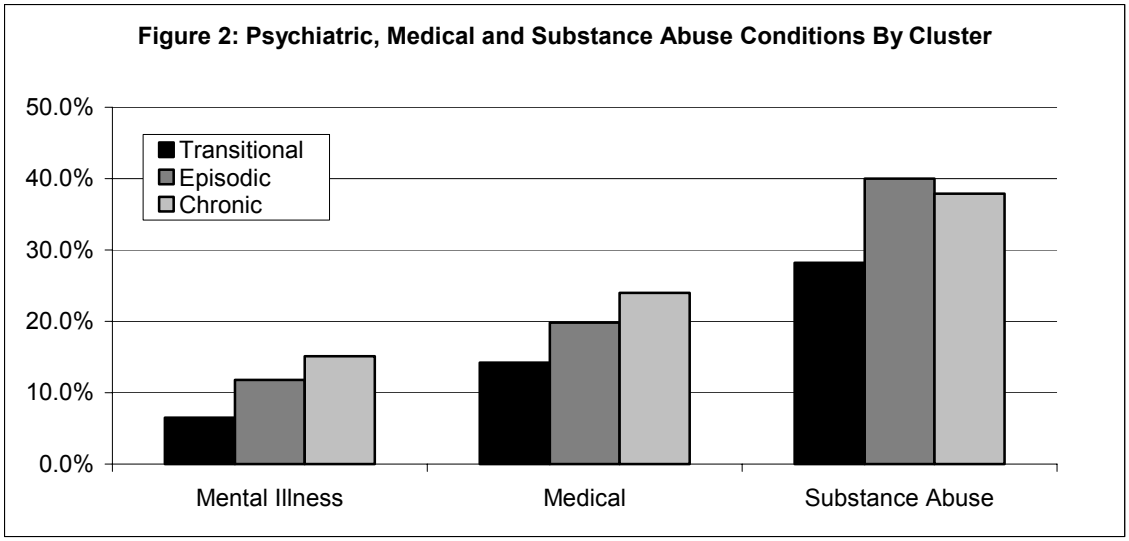
To expand on this, we would like to report the results of two studies in which we have participated. The first was authored by Culhane and Randall Kuhn (1998), on patterns of shelter use among single adults in New York City and Philadelphia. In our study, we grouped shelter users based on the number of episodes of shelter use a person had and the number of days they stayed in a shelter over a three-year period. The model produced three groups. Illustrated in Figure 1 with the Philadelphia results, the majority of homeless single adults fall into a category we called *transitionally homeless.* Persons in this group experience, on average, 1.2 episodes of shelter use that last an average of 20.4 days. About 78% of all shelter users are in this group, and they consume almost one third of all shelter days. Persons in the second group, which we called the *episodic shelter users,* have, on average, 3.8 episodes of shelter use and stay an average of 72.8



days cumulatively over a three year period. About 12% of shelter users fit this case profile, and they use about 18% of the system days. Comprising the last 10% of the shelter users is a group we called the *chronic shelter users*. Persons in this group have consumed, on average, 1.5 shelter episodes and 252.4 shelter days in a three-year time span. Interestingly, while the chronic shelter users account for only about 10% of shelter users, they consume 50% of the shelter system days. This relatively small group therefore represents about *half* of the sheltered population on a given day. The chronic and episodic shelter groups not only use a disproportionate share of shelter resources, but they also exhibit substantially higher rates of psychiatric, medical, and substance abuse conditions. Figure 2 illustrates this with the Philadelphia results.

The chronic shelter users should clearly be the target of permanent housing programs. This is a relatively older population with many special needs, with 55% having some self-reported health problem in NYC (mental health, medical or substance abuse) and 85% having some self-reported or treated health problem in Philadelphia (including 15.1% with severe mental illness, 37.9% with substance abuse, 24.0% with some physical disability). By transferring such persons to permanent housing, a very significant conservation of resources in the emergency shelter system could be achieved (as we will discuss in detail later). Based on their pattern of shelter use, the chronic shelter users are stable, and their circumstances do not constitute an "emergency." It is therefore inappropriate that half of the emergency shelter system's resources are devoted to providing what is essentially permanent housing for this relatively small part of the population. It is noteworthy that this group is also likely to be significant users of health programs; so more appropriate and stable housing could also help to reduce their over-utilization of health services (see below).

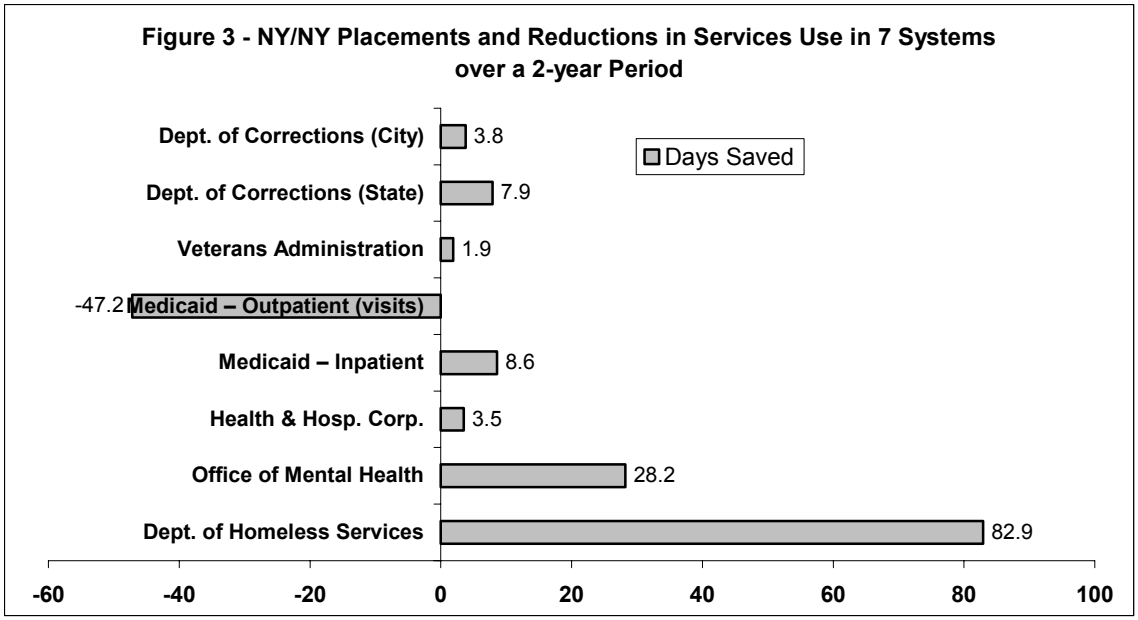
The episodic shelter users are younger than the chronic shelter users, but have fairly high rates of health conditions as well (medical, mental health and substance abuse), with approximately 52% having a self-reported condition in NYC and 66%



having a self-reported or treated condition in Philadelphia. We believe that this group is largely comprised of people who are among the street homeless, and who shuttle among various institutions (jails, hospitals, detoxification centers) in between shelter stays. Because they are likely to be much more unstable than the chronic shelter users, but not sufficiently assisted by "emergency" services alone, this group should be targeted for transitional housing programs, and/or residential treatment programs. Currently, transitional housing programs are often not targeted to this population, and it may be worth considering a requirement that transitional housing resources be targeted to this traditionally difficult to serve population. Again, this is a relatively finite population of persons, and their instability and treatment needs likely create many problems for related service systems, as well as for the public.

These two groups of homeless provide a much smaller target population from which the VA can select veterans for its housing and rehabilitation programs, and it is in targeting these veterans that the VA may be able to facilitate the greatest reductions in homelessness. The "chronic" and "episodic" shelter users comprise a relatively small percentage of persons who become homeless, yet they are the most visible and the heaviest consumers of homeless services among this population. However, in targeting this group two things must be kept in mind: first, that providing housing and material support are as important to ameliorating homelessness as clinical and rehabilitative services; and second, that these services must be available on a long-term basis, especially to those homeless with physical or psychiatric disabilities.

To illustrate this, we will briefly summarize a second study that we conducted with our colleague Trevor Hadley (Culhane, Metraux & Hadley, in press) on providing supportive housing – housing with social and psychiatric support services – to mentally ill homeless and its effect on the use of health care, correctional and shelter services. The study examined services use by formerly homeless persons with SMI before and after being placed into "New York/New York" (NY/NY) housing, a large housing program in



New York City (NYC). Administrative data from public health care, mental health, criminal justice, and shelter service providers are used to assess the aggregate level of demand for services, pre- and post-intervention, for the study group as compared to a group of matched controls, and to assess the degree to which service reductions offset the costs of the supportive housing.

In 1990 New York State (NYS) and NYC agreed to jointly fund and develop 3,600 community-based permanent housing units for homeless persons with SMI under what became known as the New York/New York Agreement to House the Homeless Mentally Ill. This initiative was in response to problems with homelessness and community mental healthcare in NYC that were perceived to have reached crisis proportions. The NY/NY Agreement, in providing housing with psychosocial services for homeless persons with SMI, was designed to target those who were among the most chronic and difficult to serve among the homeless population, and to ease demand on public shelter and psychiatric treatment services.

The placement of homeless people with severe mental illness in supportive housing is, as expected, associated with substantial reductions in homelessness. Not only do homeless people with severe mental disabilities placed in housing have marked reductions in emergency shelter use, they experience marked reductions in their use of hospital and correctional facilities as well. Results show that such persons are extensive users of publicly funded services, particularly inpatient health services, *accumulating an average of $40,449 per year in health, corrections and shelter system costs*. As shown in Figure 3, placement in NY/NY housing was associated with a subsequent reduction in services use across all systems studied except for Medicaid-reimbursed outpatient services. Translating these reductions in service use into dollar amounts, *NY/NY is associated with a combined savings $16,282 per housing unit per year*. The vast majority of these service use reductions were in health services, which accounted for

72% of the cost reductions. Approximately 23% of the cost reductions came from a decline in shelter use; 5% came from reduced use of state and city jails.

Use of inpatient VA services by people in this study also declined significantly. People placed in housing had a 33% reduction in VA inpatient admissions once placed in that housing. Moreover, there was a 50% reduction in the total number of VA hospitals days used by people once they were placed in housing. This reduction is due not only to fewer hospitalization episodes, but to a 25% reduction in the number of days stayed in the hospital once admitted, presumably because access to permanent housing made discharge and management of the illness in a non-hospital setting more achievable.

In light of the high cost of homelessness, the importance of the effect we found – that the supportive housing intervention significantly reduces these costs – is further reinforced. For neither the public nor the people with SMI who are homeless derive a benefit from unnecessary or unnecessarily long hospital stays and incarcerations, whereas the service cost reductions associated with a housing placement represent a demonstrable benefit, both to the public and to the formerly homeless. Comparing these service reductions to the estimated annual $17,277 cost for each NY/NY supportive housing unit results in a modest cost of $995 per housing unit per year over the first two years of placement. Service reductions offset 95% of the costs of the supportive housing.

Although this study was limited to one locality, and cannot be generalized to all urban areas, the results could have important public policy implications. Research suggests that as many as 110,000 single adults with severe mental illness are homeless on a given day in the United States, and as many as 260,000 single adults are chronically homeless.[1] If such persons, or even significant proportions of them, are extensive users of acute care health services, public shelters, and criminal justice systems, then the results of this study would suggest that an aggressive investment in supportive housing is warranted. While such housing may not be appropriate or effective for every person who is homeless and mentally ill, sufficient proportions would likely benefit such that their placement in housing could significantly offset the costs of a targeted initiative, such as was demonstrated here. In effect, it is quite possible that policymakers could substantially reduce homelessness for a large and visible segment of the homeless population – often thought to be stubbornly beyond the reach of the social welfare safety net – at a modest cost to the public.

What could the VA do to improve its programs for people who are homeless? First, as these studies demonstrate, reducing homelessness, particularly among the most long-term homeless, is not only the humane thing to do, but is in the best interest of public service systems like the VA and to tax payers. The VA should do whatever it can to improve its placement of people who are homeless, particularly people with disabilities and other health problems, in permanent supportive housing. Unlike many homeless adults, many veterans have a veteran's income benefit, as well as a dedicated health system, which could establish a priority for placing people in subsidized housing

[1] See manuscript for derivation.

with the necessary supportive services provided. Second, veterans' programs could work more quickly to identify people at risk of homelessness and prevent their discharge from VA hospitals into public shelters. Again, where necessary, the VA could assist people in finding permanent housing placements, in accessing the necessary income benefits to help pay for the housing, and in providing supportive services that will make the housing work. Finally, for those veterans who are not stable enough to manage independent living, even with what supportive services provide, the VA should develop more transitional housing and residential treatment options that remove them from the general adult shelters, and better coordinate their recovery, treatment and housing needs. Such transitional programs could become an intermediate placement for people who are eventually able to stabilize in permanent housing programs.

In conclusion, based on the research we have conducted, we believe that permanent solutions to homelessness for veterans, particularly veterans with mental health and substance abuse problems, can be achieved. Potential savings in VA hospital costs, reduced shelter costs, reductions in criminal justice system costs, and improvements in the quality of life for veterans provide ample support for renewed commitment to supportive housing and residential treatment solutions to homelessness.

Thank you for this opportunity to testify. We would be glad to answer any questions.

References

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